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Published in:
European Journal of Obstetrics & Gynecology and Reproductive Biology

DOI:
10.1016/j.ejogrb.2019.11.011

Publication date:
2020

The ethics of fertility treatment for same-sex male couples: considerations for a modern fertility clinic

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Abstract

Social and legal equality for same-sex male couples continues to grow in many countries. Consequently, increasing numbers of same-sex male couples are seeking assisted reproductive technology to achieve parenthood. Fertility treatment for same-sex male couples is an undoubtedly complex issue and raises a variety of ethical concerns. Relevant considerations include ethical issues relating to the surrogate and a possible egg donor, the commissioning same-sex couple, the welfare of the child and the fertility clinic itself. This work analyses these arguments in the context of modern fertility services, providing reflection on the evidence present and what it means for clinicians today. Herein, we argue that fertility treatment for same-sex male couples via surrogacy agreements are acceptable, subject to considerations of each individual case, as in all assisted reproductive treatment. It is in the interest of open and equal access to health services that barriers to assisted reproductive technology for same-sex male couples should be minimised where possible.

Keywords: Same-sex male couple, LGBT, ethics, surrogacy, assisted reproduction.

Introduction

The last 50 years have seen a drastic shift in the social acceptance of homosexuality in the western world [1]. Expanding legal recognition of same-sex unions, be it through civil partnerships or marriage, have redefined traditional ideas of who can choose to have children. As a result of this growing social and legal equality, the number of same-sex male (SSM) couples seeking to achieve parenthood outwith any previous heterosexual relationships via co-parenting, fostering, adoption or surrogacy has risen. Indeed, growing numbers of non-heterosexual men are now seeking medical assistance to have biological children [2–4]. This change in reproductive practices, coined by press of the late '80s and early '90s as the '*Gayby Boom*', continues to spark controversy [5].

Assisted reproductive technology (ART) for SSM couples present a unique issue for some, as they fundamentally challenge what is considered basic reproductive biology [6]. Instead of coital conception or heterosexual ART, achieving biological parenthood for SSM couples always involves third parties, i.e. a surrogate and possibly an egg donor. Furthermore, SSM parenthood is not accepted in all countries, with concerns for welfare of the child historically often at the forefront of criticism. Critics amplify these concerns in a setting such as the UK's NHS, where use of limited public funding to treat SSM couples – who are arguably *socially* and not *medically* infertile – is considered financially irresponsible [7]. However, despite this criticism, Scotland – a liberal country with a generous history of state-funded fertility treatment – recently made news as the first country in the UK to fund IVF for a SSM couple [8]. Regardless of any of these criticisms, or sources of funding, the number of SSM couples seeking to explore their fertility treatment options will rise in future, and clinics and practitioners need to be prepared for it.

In assisted reproduction for a SSM couple the interests of a number of people are at play: up to two women (surrogate and egg donor), the commissioning couple and their families; the child; the treating healthcare professionals; and, one could argue, society as a whole. Consequently, it is essential that those involved in providing fertility treatment to SSM couples fairly consider the ethical issues, and that such considerations are free of prejudice in order to provide treatment and support that is moral, fair and socially justifiable. It should also be borne in mind that, in a significant number of countries, there is a legal duty not to unfairly discriminate based on sex or sexual orientation – for example, the UK's Equality Act (2010) [9]. We will thus examine the arguments that are commonly used by those who oppose, or at least have concerns about, fertility treatment for, or child rearing (or both), by SSM couples. These arguments can be subdivided into: a) issues encountered through the egg donation and gestation surrogacy process; b) issues for the commissioning couple; and c) issues regarding welfare of the child.

a) Issues for the egg donor and surrogate

If a SSM couple wish to have a biological child then surrogacy, and possibly other-party egg donation, are essential. As such, a variety of ethical concerns accompany what has become a supply and demand market for providers of third-party reproductive services. It should be noted that these ethical issues are not unique to SSM couples, and apply to many other surrogacy agreements. We include them here for completeness.

Although egg donation and surrogacy are can be roles fulfilled by the same woman, this is not always the case. Regardless of whether the eggs come from the planned surrogate or someone else, the risks involved with each role differ significantly, and need to be considered separately. Kenney and McGowan [10] reported that egg donors in the US retrospectively

cite both altruistic and financial motivations in their decision to donate. For these women, risk fell into two main categories – physical and psychological – and concerns exist in regard to pre-treatment awareness of the two types of risk. Although such recall data are limited, a fifth of the sampled women reported not being aware of any risks associated with the egg donation process, and only a third reported awareness of ovarian hyperstimulation syndrome (OHSS), a serious and common complication of the egg donation process. This risk is not without consequence, as moderate to severe OHSS affects 3–8% of all cases of ovarian stimulation [11]. Given that OHSS is an iatrogenic complication of optional treatment with a potentially fatal outcome, the ethical issues are significant [12]. Hence, healthcare professionals should take care to reduce these risks on an individual basis whenever possible. Encouragingly, pre-donation awareness of psychological risks was found to reflect more challenging outcomes than the generally positive emotional reaction the donors actually experienced [10]. These findings emphasise the importance of adequate pre-treatment information and counselling for women choosing to donate eggs for a SSM couple. Furthermore, the counselling must prepare donors for the possibility of future contact from donor-conceived children in the UK and the psychosocial implications this could have [13].

Secondly, surrogacy is in itself ethically challenging. The risks of pregnancy, even for a woman considered healthy, are not insignificant. In the UK in 2013–15, 3.8 per 100,000 women died due to complications of pregnancy either during the pregnancy or in the six-week period after the pregnancy had ended [14]. In a surrogacy arrangement all the risks of pregnancy, and possibly those of donation, are adopted by the surrogate who agrees to carry a child with the intention to relinquish it to the commissioning couple. Critics suggest that this type of agreement objectifies and unnecessarily medicalises the surrogate, making her vulnerable to exploitation. Furthermore, some consider surrogate pregnancy a high-risk

emotional experience and argue that it subordinates the wellbeing of the surrogate and the child by sacrificing their relationship to satisfy the commissioning couple [15, 16]. Although qualitative studies of surrogate experience often comment on inherent risks, most agree altruistic surrogacy is a positive experience [16,17].

In the UK, legislation [18] prohibits commercial surrogacy in an attempt to reduce the potential for exploitation, in theory permitting altruistic agreements with remuneration of only reasonable expenses. It is, however, unclear if such legislation is successful in protecting women: even if women in the UK are protected to a higher level than in the absence of legislation, the number of clandestine financial payments that surrogates and egg donors receive is uncertain but definitely non-zero. There is, however, significant difference in laws internationally, and many couples seek to bypass UK safeguards by extending their surrogacy search overseas, where women may receive payment, but be less effectively protected from exploitation.

Although commercial surrogacy is a contentious topic, provided appropriate protections are in place it may represent a suitable option for SSM couples. Reports suggest that in some US states where commercial surrogacy is permissible, such a system may work well to facilitate successful surrogacy experiences in which relationships between surrogates, children and commissioning parents are found to be positive [19].

Additionally, as surrogacy agreements cannot be enforced in the UK by or against any of the persons making the arrangement, such situations leave the surrogate, any partner the surrogate may have, and the commissioning couple, vulnerable to the other party renouncing their position and choosing to abandon any prior agreement. Such uncertainty necessitates the

involvement of counselling and independent legal advice. In recent years, there have been substantial calls, spearheaded by prominent surrogacy agencies, to reform UK law and address areas of concern, particularly to Parental Orders [20]. Such lobbying has successfully secured funding for the UK Law Commissions to begin a joint consultation to reform current law which will ideally improve transparency relating to surrogacy for couples in the UK [21].

Respecting the autonomy of those involved in a pregnancy arrangement for a SSM couple is important, however it is essential to recognise that certain restrictions on autonomy are agreed upon. As a result of these complexities it is essential that those involved seek both counselling and legal advice, and all ART providers should assist patients in doing so [22]. This may not be the case in some countries where affluent Westerners go to find surrogates. Nevertheless, altruistic surrogacy arrangements are currently acceptable in the UK. Provided safeguards are in place to protect those involved fertility clinics should act with caution, but not allow this to act as a barrier for SSM couples to have biological children.

b) Issues for the commissioning couple

There are a particular set of issues that SSM couples face when looking to achieve biological parenthood, and some of these issues relate to the complexities and uncertainties relating to surrogacy. As aforementioned, in the UK, although legal surrogacy agreements are often required, they are not enforceable in law. When a child is born, the birth mother/surrogate is the child's legal parent at birth. The commissioning couple must then apply for a Parental Order once the child is born, which, if granted, transfers parental rights to them. This process cannot begin until six weeks after the child's birth [13,18]. In this interim period, the commissioning couple may be unable, for example, to make medical decisions on their child's behalf.

Another issue is that one child can have only one biological father, requiring identification of a single intended genetic parent by each SSM couple. Although the value of parent-child biological ties has been convincingly argued to be minimal – see Di Nucci [23] – such ties may, particularly when unequal in a parental unit, affect prospective parental power, influence and responsibility in ways that are not fully understood. To circumvent such issues some SSM couples may seek fraternal twinning with dual paternity as a solution. Though such practices are not licensed in the UK, such approaches have been idyllically portrayed online [24–26] with little consideration of the ethical implications of double-embryo transfer and consequent multiple pregnancy, which are broadly considered as the single greatest risk of fertility treatment [27]. Such arrangements may fit with some SSM couples' perceived ideal family structure, but clinics have a responsibility to counsel both couples and surrogates as to why fraternal twinning carries significant risks and to discourage couples seeking such treatment overseas.

Lastly, SSM couples are not immune to the well-documented emotional, financial and time-related costs of ART and they may bear an additional burden of guilt for subjecting third-parties to such risk [28]. For these couples, success of treatment is reliant on the continued co-operation of third-parties and the availability of funding which cannot be guaranteed through multiple ART cycles that may be required. Even if such arrangements are successfully realised, it is important to remember that ART does not guarantee an embryo, pregnancy or healthy live birth and SSM couples must, through adequate pre-treatment counselling, understand this reality.

c) The welfare of the child

When deviations from a traditional nuclear family are seen, debate often shifts from the best interests of the parents to the welfare of the child. It should be evident that welfare of the child ought to be the most important consideration in any aspect of reproductive medicine. Yet, Pennings and Mertes [29] comment on how the shift from heterosexual to homosexual parenthood triggers a discrete range of concerns, where raising a child outwith a heterosexual relationship – where both parents share a direct genetic relationships with their children – is assumed to have suboptimal outcomes for the child [30]. Largely following from the 'gay adoption' debate, a growing body of research evaluating the psychological and physical welfare of children with same-sex parents concludes that overall mental health and general wellbeing of the children of same-sex parents does not differ compared to children of heterosexual parents [31–35].

Critics of SSM parenthood argue that children need both a mother and a father in order to recognise gender roles and develop '*normally'* [36]. Studies commonly used in support of this argument are Regnerus [37] and Allen, Pakaluk and Price [38], where suboptimal outcomes were described for children of same-sex parents in multiple domains (education, employment and mental health). However, these studies have been widely criticised by peers for poorly handling data-sets and failing to account for confounding factors such as family breakdown, therefore not uniquely considering children who have been raised by same-sex parents [39,40].

The 'need for a father' forms a debate that has been persistent in the UK for a number of years, often serving to criticise the parenting ability of single mothers. The 'need for a father' often assumes, however, that a mother was present by default – which is not the case when considering SSM couples. In 2008, the Human Fertilisation and Embryology Act removed a

clause which required fertility clinics providing treatment to consider a child's need for a father figure, requiring instead that prospective parents show they can provide 'supportive parenting' [13,41]. This inclusive change in legislation illustrated how the legal – and maybe societal – consensus was that the absence of a father or indeed parental gender has no detrimental effect on the wellbeing of a child.

Child welfare concerns could be argued based on the increased likelihood of a child parented by a SSM couple not receiving breast milk in early life. Breastfeeding is widely regarded to improve both mother and infant wellbeing [42]. However, despite the well-documented benefits of breastfeeding, rates remain poor, particularly in high-income countries [43]. Nonetheless, an Australian study found over one fifth SSM parents managed to provide some breast milk to their child in early life, usually via surrogate donation [44]. With respect to the low prevalence of breastfeeding in the general population and the social acceptance of bottle-feeding, limiting SSM couples' fertility options based on breastfeeding concerns seems unreasonable if current practices persist.

In the context of same-sex parenting, most child welfare data present analyses of same-sex parenting as a whole. Commonly the SSM couples included in studies with children present in the household are as a result of adoption or a previous opposite-sex relationship. However, the data suggest that being raised by same-sex parents has no negative developmental or psychological outcomes for a child, nor does it result in differing gender identity, gender role behaviour or sexual partner preference compared to opposite-sex parents [45–48]. Such data indicate that historical concerns that homosexuals wish to have children to reproduce homosexuality is inaccurate. This argument has, firstly, never been evidence-based and, secondly, only holds as an argument if homosexuality is to be considered as a negative trait

or a form of harm [31]. This attitude is clearly dependant on the societal acceptance of homosexuality and it has been reasonably argued that subjecting a child to gay parents in an overly homophobic society is indeed harmful [49].

Gay men have a demonstrably higher incidence of most psychiatric disorders [50]. We know that perceived societal discrimination correlates strongly with mental health in homosexual men [51]. Sceptics use these population statistics to suggest that these mental health issues impact on the parenting ability of SSM couples. In the fertility context, if child welfare is an issue as a consequence of mental health concerns, then decisions should be made on a case-by-case basis. Therefore, limiting the reproductive options for SSM couples based on population wide mental health trends is inappropriate.

The vilification of homosexual men as promiscuous or paedophilic has long been a powerful rhetoric to incite public hostility towards homosexual men. Sexual abuse from homosexual male parents is a notion that still pervades in the minds of some, despite the historical absence of evidence to support it [52,53].

Many SSM couples considering parenthood are concerned that their child will experience social stigma, social exclusion or bulling in their school years due to their non-conventional family structure. A recent study found that children of same-sex parents experienced ‘feeling different’ and microaggressions from peers [54]. Microaggressions – including heterosexism, public outing and bullying – were experienced by most children, however, they reported them at a low to medium intensity and with neutral emotion. Encouragingly, this study found that children’s positive feelings about their family structure were more commonly reported than feelings of difference or microaggressions, explaining that children often cope with such

experiences with resilience. Yet, more can be done to ensure social support structures are in place so that school environments can be safe places for minority families and recommendations by which to achieve this are present [55].

The arguments that SSM couples have more psychological issues, that they will produce homosexual children or that their children will be bullied all hinge on a negative societal view of homosexuality and consequently, SSM relationships. Disappointingly, these arguments – through their citation of social prejudice – further stigmatise SSM couples. Firstly, they blame the victim. It must be emphasised that the responsibility for societal stigma should not fall to SSM couples, but instead those who choose to propagate it. Secondly, they weaponise societal prejudice and discrimination to fuel further discrimination, with significant cost. Lastly, blaming society allows individuals to absolve themselves of responsibility for their own intolerance. Societal acceptance and equality of SSM couples would go far to eliminate many of these concerns.

The body of research illustrates the homophobia and heterosexism inherent in society by using heterosexual families as control groups on which to compare homosexual families. These studies regard heterosexual parenthood as a 'gold standard' and they determine the acceptability of homosexual parenthood by comparison, often coming to a 'no difference' conclusion. Pennings and Mertes [29] argue that this method is fundamentally flawed: if evidence showed superior parental competence of homosexual parents, it would be absurd to think that heterosexual couples would be denied fertility treatment. Therefore, the converse should not be considered. It is frustrating that such studies are required to reassure sceptics who assign a burden of proof on those they wish to discriminate against. Pennings [56] comments how morally revealing it is that many clinics accept dangerously high heterosexual

multiple pregnancy rates which carry significant risks for the children but use the argument against multiple pregnancies to restrict access to treatment for non-heterosexual parents-to-be. Heterosexism need not be an inevitability; a more appropriate approach would be to quantify child welfare and compare to what we consider acceptable parameters. It may be true that the children of gay parents have poorer outcomes, but that does not mean they are unacceptably poor. Instead of limiting the reproductive options these families have, understanding why they may have difficulties and how they can be supported would be a fairer approach.

Discussion

With regard to egg donation and surrogacy, regulation and clinic level assessment are important in ensuring that women are fully informed and are donating or entering into surrogacy agreements for appropriate reasons. It is important to remember that SSM couples cannot fall into parenthood by accident like many heterosexual couples do. SSM couples must think very seriously about embarking on a journey of parenthood, just as any other couple who decide to use the services of fertility clinics. It is, however, unfair that SSM couples should be subjected to higher level of scrutiny for doing so. Additionally, expecting SSM couples to prove their ability to parent with threats of limiting parenthood if outcomes are suboptimal perpetuates the idea that discrimination based on sexual orientation is acceptable. The welfare of children is of course essential to consider, but arguments against SSM parenting are often imbued with a moral contempt for homosexuality and inconsistently applied.

Lastly, SSM couples may pose unique ethical and logistical challenges for individual fertility clinics. It is important to be aware of such issues to allow them to be properly prepared for,

and hence not affect patient care at the point of access. Conscientious objection by some clinic staff to the treatment of SSM couples may be an issue. It is essential that clinics identify any concerns present among staff and plan appropriately to either a) ensure other staff members are available to treat such patients or b) clarify that if other staff members are unavailable, it is inappropriate for conscientious objection to interfere with medical care. Also, it is important that clinics are adequately resourced to manage SSM couples given the additional associated complexities. Furthermore, clinics should make it clear to patients that such services are available. Research suggests that clinics often fail to provide online information for same-sex couples and this is often the first point of contact with potential patients [57]. This example illustrates how steps to integrate equality and diversity into aspects of care as simple as patient information can help minority groups feel less marginalised and more accepted, and this is something we should strive to achieve.

Reflecting changes in the social zeitgeist with the care we provide is essential. Indeed, unconscious biases of healthcare professionals may play an important role, but such influences await further investigation. ART for SSM couples has both benefits and risks, and the balance of these may change as ART advances, pregnancy becomes safer, laws change and social attitudes shift. Many of these risks are unique to SSM couples, but most are not. Nonetheless, SSM parents are here to stay, and modern fertility clinics should afford them the respect they deserve. After all, equality, inclusivity and diversity are aspects of the care that healthcare professionals provide, that they can look back on and be proud of.

Acknowledgements

The authors would like to thank Dr Steven Gellatly and Dr Vanessa Kay for their comments on this manuscript.

Disclosure of interest

No potential of conflict of interest.

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